Results Currently a work in progress and we are in the process of evaluating this work.

Conclusion A culture of engagement is more likely to predict performance than any other variables including competence (Alimo-Metcalfe & Bradley, 2010). Through discussion and exploration we are able to expand upon learning and explore decision making. Disseminated learning allows for more openness and transparency amongst the team. There is a shift from the perception of a 'blame culture' to one of collaboration, inclusiveness and participation. Including staff who delivered the front-line care in these scenarios and discussions further enriches the process.

P-160 THE BOTTOM LINE – NO PRESSURE!

Anne Marie Jones. *Garden House Hospice Care, Letchworth Garden City, UK*

10.1136/bmjspcare-2017-hospice.185

Managing pressure injuries within palliative care patients has been shown to be challenging due to, decreased nutritional intake, reduced mobility and increasing frailty resulting from co-morbidities. Included in this would be patients taking steroids and those with complications from treatment which would compromise their skin integrity. Due to high numbers of patients being admitted to the inpatient unit with pressure injuries it was felt that reducing further deterioration of their pressure areas was paramount.

Aim The Tissue Viability Link nurse role is to initiate and incorporate creative ways to educate staff about the importance of preventing deterioration of pressure injuries in our patient group and keep staff up-to-date with the latest initiatives.

Method • A tissue viability focus group was developed to look at areas to improve the management of pressure injuries within the hospice

- A new policy has been devised incorporating the SSKIN algorithm and NICE guidelines
- Training sessions developed and delivered at nursing handovers and at away days
- A laminated pocket guide produced to enable staff to grade pressure injuries. An enlarged version of this was made for all the patient folders
- A patient and carer information leaflet produced about managing pressure injuries
- Heel mirrors purchased and informative sign produced so staff are reminded to use them
- Guidelines on type of wound dressings produced to streamline which dressings would be used
- 'The Bottom line' newsletter published bi-monthly covering relevant information for staff, interesting facts, 'Don't forget' section, 'News in Brief' section to keep staff updated
- SSKIN charts which are helping to prompt staff with repositioning our patients.

Results Mini audit and Hospice UK audits carried out have shown that the staff's knowledge and ability to recognise and put measures in place to minimise pressure injuries and complete necessary documentation has greatly improved.

Recommendations To continue to publish newsletter for staff and find innovative ways to raise staff awareness about ways to implement preventative measures. To continue to carry out Hospice UK audits within the allocated timeline.

P-161 IMPROVING THE CONTENT AND TIMELINESS OF DISCHARGE LETTERS FROM A HOSPICE INPATIENT UNIT

Joanne Rimmer, Aruna Hodgson. *Wigan and Leigh Hospice, Greater Manchester, UK*

10.1136/bmjspcare-2017-hospice.186

Background When a patient is discharged from an inpatient setting back into the community, essential information about their condition and its treatment must be communicated accurately and efficiently via a comprehensive discharge letter to the relevant health care professionals.

Aims To audit the content and timeliness of discharge letters from a hospice inpatient unit and rectify deficiencies identified by agreeing and implementing effective interventions.

To re-audit the impact of changes made, thereby completing the audit cycle.

Methods An initial audit identified that the standards for hospice discharge letters were not being met in several areas. Following this, four main strategies were implemented to achieve improvements:

1. Introduction of a discharge letter proforma
2. Enhanced communication systems between the medical team and clinical secretaries
3. Discharge letters faxed, rather than posted to ensure timeliness of delivery
4. Ongoing monitoring of when letters were being sent, with quarterly reports presented to the medical team.

One year following introduction of these changes, a retrospective re-audit was undertaken of twenty-five consecutive patients discharged from a hospice inpatient unit.

Results All areas of deficiencies previously identified were improved upon in the re-audit. The discharge letter proforma succeeded in standardising the format and content of letters, ensuring key positive and negative information was recorded. The systems put in place to ensure timeliness of letter-sending resulted in 96% being sent out within one working day, (versus 45% previously). These improvements have enhanced communication between the hospice, hospital and community.

Conclusions Further alterations to hospice discharge letters and ongoing monitoring are required to maintain and optimise standards. The audit work undertaken has demonstrated that effective clinical changes can be achieved through collaboration with colleagues to agree achievable action plans, and by ongoing good team working to attain high standards and additional improvements in practice.

P-162 ENHANCING DISCHARGE PROCESSES

Tracy Parkinson, Janet McGeown. *St Catherine's Hospice, Preston, UK*

10.1136/bmjspcare-2017-hospice.187

Background Review of discharge processes was identified as a workstream within an overall in-patient unit project modernising ways of working to meet current service demands. Staff feedback showed increasing anxiety relating to completion of the discharge process and documentation, in particular relating to continuing health care funding. Anecdotally it was also felt that patient and family expectations of ongoing hospice care were a barrier to timely discharge planning.

Aims

1. Increase in number of patient discharges
2. Reduction in length of stay